641—201.2(135,75GA,ch158) Definitions.

"Accountable health plan (AHP)" means a type of organized delivery system.

"Commissioner" means the commissioner of insurance.

"Coverage decision" means a final adverse decision based on medical necessity. This definition does not include a denial of coverage for a service or treatment specifically listed in plan or evidence of coverage documents as excluded from coverage.

"Department" means the department of public health.

"Director" means the director of the department of public health.

"Emergency medical condition" means a medical condition that manifests itself by symptoms of sufficient severity, including but not limited to severe pain, that an ordinarily prudent person, possessing average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in one of the following:

1. Placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.
2. Serious impairment to bodily function.
3. Serious dysfunction of a bodily organ or part.

"Emergency services" means covered inpatient and outpatient health care services that are furnished by a health care provider who is qualified to provide the services that are needed to evaluate or stabilize an emergency medical condition.

"Enrollee" means an individual, or an eligible dependent, who receives health care benefits coverage through an organized delivery system.

"Essential community providers" means those publicly funded health care providing organizations which the director deems to be vital to a local health care delivery system to ensure that all vulnerable populations in Iowa have assured access to health care.

"Independent review entity" means a reviewer or entity, certified by the commissioner pursuant to Iowa Code section 514J.6 [1999 Iowa Acts, chapter 41, section 12].

"Organized delivery system (ODS)" means an organization with defined governance that is responsible for delivering or arranging to deliver the full range of health care services covered under a standard benefit plan and is accountable to the public for the cost, quality and access of its services and for the effect of its services on their health. The organization operating as an ODS shall assume risk and be subject to solvency standards as found in 201.12(135,75GA,ch158).

"Primary care" means essential, community-based health care services that are coordinated, comprehensive, accountable and accessible on a first contact and on an ongoing basis. Primary care includes diagnosis and treatment, prevention, maintenance, management of chronic problems, and linkages for specialized care.

"Standard benefit plan" means, at a minimum, the same benefit plan that is required of small group insurers under Iowa Code chapter 513B.

"Utilization review" means a program or process by which an evaluation is made of the necessity, appropriateness, and efficiency of the use of health care services, procedures, or facilities given or proposed to be given to an individual within this state. Such evaluation does not apply to requests by an individual or provider for a clarification, guarantee, or statement of an individual's health insurance coverage or benefits provided under a health insurance policy, nor to claims adjudication. Unless it is specifically stated, verification of benefits, preauthorization, or a prospective or concurrent utilization review program or process shall not be construed as a guarantee or statement of insurance coverage or benefits for any individual under a health insurance policy.